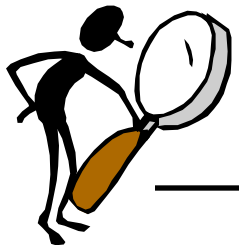

Focus on benefits for retirees

2005 Open Enrollment Edition

Open Enrollment is from Oct. 14, 2005 through Nov. 14, 2005

Inside this edition:

Health Plan Changes --New CIGNA service area, increases to Kaiser and CIGNA Rx copays, new ID numbers for CareFirst plans. New dependent child definition. *Page 2*

Enrolling in Delta Dental – if you enrolled in Dominion's self-pay plan instead. *Page 3*

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NEW Qualified Status Change Events and Dependent Definition *Pages 14-16*

REMINDER:

If you are not changing health/ dental plans or coverage levels you do not need to send in a form.

To obtain a form to change coverage, contact the Retirement Administration Agency at 703-279-8200 or 800-333-1633.

If you had County dental coverage as a retiree in 2004 but did not enroll in Delta Dental last year, you may enroll by submitting an enrollment form and proof you had the

Board of Supervisors Approves 2006 Increase to Retiree Health Subsidy Using Savings From Medicare Part D

As you may already be aware, the federal government will be offering Medicare eligible retirees a new prescription drug benefit effective January 1, 2006. Medicare's new "Part D" benefit will provide partial coverage of outpatient prescription drugs for individuals who elect this benefit. While retirees who are covered under County health plans have pharmacy benefits, many other employers do not provide medical or prescription coverage for their retirees.

Medicare's open enrollment for its first year of prescription drug coverage will run from November 15, 2005 to May 15, 2006. During this timeframe, Medicare-eligible retirees, spouses and dependents will have an opportunity to enroll in this new federal program. Retirees who are covered by the County's health plan must decide whether they will keep their County coverage, drop their County coverage and enroll in a Medicare Part D plan, or have both types of coverage.

To encourage employer plans to continue to provide pharmacy benefits to their retirees, the Centers for Medicare and Medicaid Services (CMS) will be providing a rebate to employers who retain retiree pharmacy benefits under their health plans. The rebate will be provided for each retiree who does not enroll in Medicare Part D. In recognition of this expected rebate from CMS, the Board of Supervisors approved an increase to the retiree health care subsidy for calendar year 2006 only. For 2006, retiree subsidies will increase by an average of 25%, and the subsidy will be standardized for retirees who are both under and over 65 (see charts on page 3). Retirees who are grandfathered at the $100 subsidy level will receive the 2006 subsidy increase based on their age and service.

Retirees with Medicare must decide whether to:

- ***Reject Medicare Part D (for now) and keep the County health plan***
- ***Enroll in Medicare D and drop the County health plan forever***
- ***Pay the monthly charges for both***

Although the County's health plans offer prescription drug benefits that are as good as or better than Medicare's standard benefit, Medicare-eligible retirees should evaluate both the County plan and the Medicare Part D plan to determine which plan is best for them. In making their decision, retirees will need to keep in mind the increased subsidy that they will receive under the County plans for 2006. ***Retirees must also understand that if they drop the County's plan they will not be able to re-join the plan in the future.*** Retirees will, however, be able to enroll in a Medicare prescription drug plan in the future, without a late enrollment penalty, as long as they remain covered under the County's plan.

New increased subsidy and premiums at the 2006 rates will be reflected in the December retirement check.

Changes for 2006

- ***CIGNA's Service Area Now Covers Most of Virginia;***
- ***Prescription Drug Costs Increase for Kaiser and CIGNA;***
- ***FairChoice and BluePreferred Issue New ID Numbers/Cards;***
- ***New Dependent Definition; and***
- ***Revised Qualified Change in Status Events***

CIGNA has recently expanded its service area to include all of Maryland, DC and most of Virginia. Eligible retirees under age 65 who live in the service area may elect CIGNA during Open Enrollment. Retirees are required to live in the service area of their plan based on the address they have on file with the Retirement Administration Agency. The location of the retiree's post office determines the County of residence. Retirees' whose address changes to one outside the service area must change to another plan for which they are eligible within 60 days of their move in order to maintain coverage through a County plan. For a complete list of counties in the new CIGNA service area, see page 10.

Prescription Drug Co-Payments Increase For Kaiser Permanente and CIGNA

The Kaiser prescription drug program will now have a 3-tier co-payment structure -- the lowest co-payment for a generic drug, a higher co-payment for a brand name drug on their preferred drug list and the highest co-payment is for a brand-name drug that is not on the preferred drug list (see chart). In addition, Kaiser members may receive up to a 30 day supply at the local pharmacy or Kaiser center or up to a 90-day supply by mail for lower copayments.

CIGNA's pharmacy co-payments are increasing but now you can help reduce your costs by using mail order for maintenance medications. Now you pay only 2 copayments for your prescription up to a 90-day supply if you obtain it through their mail-order pharmacy. Prescriptions from local pharmacies are limited to a maximum 30-day supply. The chart below shows the new copayments. Injectible medications will also now be covered under the pharmacy benefit instead of the medical benefit.

Pharmacy payments are increasing to reduce rising premium costs and to provide a similar benefit structure under all the County's plans.

Kaiser	**Co-payment**		
	Kaiser Center (up to 30 day)	Local Pharmacy (up to 30 day)	Mail Order (up to 90 day)
Generic	$10	$20	$16
Brand Name (preferred list)	$20	$40	$36
Brand Name (not on preferred list)	$35	$70	$66

CIGNA	**Co-payment**	
	Local Pharmacy (up to 30 day)	Mail Order (up to 90 day)
Generic	$10	$20
Brand Name (preferred list)	$20	$40
Brand Name (not on preferred list)	$40	$80

FairChoice+BlueChoice and BluePreferred PPO Issue New ID Numbers

All retirees enrolled in either FairChoice+BlueChoice or BluePreferred PPO will receive new ID cards with new ID numbers for 2006. The plans will no longer use Social Security numbers for identification purposes. There is no separate prescription card. Please ensure you provide a copy of your new identification card to all of your doctors, pharmacists or other medical providers.

Qualifying Change in Family Circumstances Rules Updated

Some of the Qualifying Change in Status Events (see the chart on pages 14-16) have been changed to bring them into conformity with federal regulations. For instance, all changes, except for adding a dependent due to birth or adoption, must now be effective on the first of the month after receipt of the enrollment form. So, if your spouse is losing coverage and is to be added to your plan, it is important to turn in your form as quickly as possible so you do not experience a break in coverage. Also, if your dependent is to be added to your plan because he or she loses eligibility for other coverage, you may elect any plan for which you are eligible.

Dependent Definition to be Changed

An eligible dependent child is now defined as any biological child, stepchild, adopted child (or child placed for adoption), or child for whom the employee/retiree has been appointed legal guardian who is:

Continued on page 6

Verifying Eligibility for Delta Dental Coverage

Retirees who had dental insurance through a County plan but who neglected to enroll in Delta Dental during the last open enrollment may be eligible to enroll during this open enrollment.

As explained in letters sent out to affected retirees last January, retirees who missed the opportunity to sign up with Delta Dental will be allowed to enroll this year if they provide proof that they had obtained coverage with Dominion Dental on an individual-pay basis for 2005. This proof may include a copy of a recent bill or 2005 enrollment card from Dominion Dental. Documentation should be submitted to the Retirement Administration Agency along with a Delta Dental enrollment form before the end of open enrollment (November 14, 2005).

Retiree Subsidy Amounts for 2006

Monthly Subsidy for Retirees Ages 55-64			
Years of Service at Retirement	**Subsidy Amount**	**2006 Supple-ment**	**2006 Subsidy Amount**
5-9	$25	$5	$30
10-14	$50	$15	$65
15-19	$125	$30	$155
20-24	$150	$40	$190
25 or more*	$175	$45	$220
*Also includes retirees of any age who are approved for a service-connected disability retirement and covered under a County health plan.			

Monthly Subsidy for Retirees Age 65 and Over			
Years of Service at Retirement	**Subsidy Amount**	**2006 Supple-ment**	**2006 Subsidy Amount**
5-9	$15	$15	$30
10-14	$25	$40	$65
15-19	$100	$55	$155
20-24	$150	$40	$190
25 or more*	$175	$45	$220
*Also includes retirees of any age who are approved for a service-connected disability retirement and covered under a County health plan.			

General Information Meetings
Health, Dental, Group Term Life Insurance, Deferred Compensation And Medicare Part D

SPECIAL RETIREE MEETINGS

Representatives from the Centers for Medicare Services will be in attendance to answer questions about Medicare D.

Wesnesday, October 26 Govt. Cntr. – Room 120C 10:00 a.m.-noon.	**Tuesday, Nov. 1** Govt. Cntr. – Rooms 9-10 10:00 a.m.-noon.

Health And Dental Insurance Premiums For Retirees
JANUARY 1, 2006 – DECEMBER 31, 2006

	Full Monthly Premium (before applying any subsidy)
FairChoice+BlueChoice	
Individual	$ 452.20
2 Party	$ 888.66
Family	$ 1,306.94
Individual with Medicare	$ 315.80
2 Party with Medicare	$ 631.59
2 Party (1 Medicare/ 1 Non Medicare)	$ 768.00
Family, 1 Medicare	$ 1,218.44
Family, 2 Medicare	$ 1,129.94
Family, 3 Medicare	$ 1,041.44
BluePreferred PPO	
Individual	$ 520.02
2 Party	$ 1,021.96
Family	$1,503.00
Individual with Medicare	$ 363.18
2 Party with Medicare	$ 726.35
2 Party (1 Medicare/ 1 Non Medicare)	$ 883.20
Family, 1 Medicare	$1,414.50
Family, 2 Medicare	$1,326.00
Family, 3 Medicare	$1,237.50
Kaiser	
Individual	$331.70
2 Party	$646.80
Family	$961.92
Individual with Medicare	$270.49
2 Party with Medicare	$540.98
2 Party (1 Medicare/ 1 Non Medicare)	$602.19
CIGNA	
Individual	$358.62
2 Party	$699.34
Family	$1,043.58
DELTA DENTAL	
Individual	$29.04
2 Party	$54.86
Family	$90.36

These premiums will be deducted from the December retirement checks.

Deferred Compensation Plan Introduces New Funds/New Provider

New Funds
Retirees who have account balances in the County's Deferred Compensation Plan will see changes in the fund offerings of the Plan's current providers – ICMA-RC, AIG-VALIC and T. Rowe Price - effective November 1, 2005. All of the current providers have been retained and will be adding new funds. Some providers will also be replacing existing funds with better performing funds. If you have money in a fund that is being replaced, your money will be automatically moved or "mapped" to the designated replacement fund. Each provider will be sending participants more details on the mapping process and dates.

The following chart shows the existing funds that will be replaced and the funds that will replace them. If you have any questions on the replacement funds, wish to know more about the new funds your provider is offering, or want to move funds within your current provider, you can contact your provider directly:

ICMA-RC
800-669-7400
Plan #: 301887
www.icmarc.org

AIG VALIC
888-568-2542
Plan #: FC457
www.aigvalic.com/fairfaxcounty

T. ROWE PRICE
(888)457-5770
Plan #: 7-58001
www.rps.troweprice.com

New Provider Added
As of November 1, 2005, the Deferred Compensation Plan will also add a new provider, Nationwide Retirement Solutions. Retirees who are not yet receiving a distribution from Fairfax County's Deferred Compensation Plan and who wish to transfer assets to Nationwide (or any of the County's providers) can do so beginning November 1st. Contact the Deferred Compensation Help Desk at 703-324-4995, TTY711 to have the appropriate forms mailed to you.

Nationwide can be reached by calling 800-769-4457 or via their website: www.national/deferred.com.

You should mention Fairfax County Plan #000816 when you call.

Nationwide is one of the nation's premier third-party administrators of deferred compensation plans, currently providing full-service programs to over 8,000 city, county and special district jurisdictions across the country, as well as thirteen states. As of June 30, 2005, Nationwide Retirement Solutions administered assets of $39 billion for 1.5 million plan participants.

Provider	Existing Fund	Replacement Fund
ICMA-RC	Vantagepoint International	VT Fidelity Diversified International
ICMA-RC	Vantagepoint Core Bond Index II	American Fund Bond Fund R4
ICMA-RC	Vantagepoint Equity Income	Hotchkis & Wiley Large Cap Val I
ICMA-RC	Vantagepoint Growth	VT Fidelity Contrafund
ICMA-RC	Vantagepoint Growth and Income	Legg Mason Value FI
ICMA-RC	Vantagepoint Aggressive Opportunities	Delaware Amer Services I
ICMA-RC	Vantagepoint 500 Stock Index II	Vanguard Institutional Index
ICMA-RC	Vantagepoint Broad Market Index II	
ICMA-RC	Vantagepoint Asset Allocation	Vanguard Total Stock Index
ICMA-RC	Calvert Social Investment Equity	Neuberger Berman Socially Responsible
AIG-VALIC	Templeton World A	American Funds EuroPacific Gr R3
AIG-VALIC	Vanguard Total Bond Market Index	PIMCO Total Return Adm
AIG-VALIC	Janus Sm Cap Value Inv	Wells Fargo Advantage Small Cap Value Z
AIG-VALIC	Dreyfus Premier Future Leaders A	Wells Fargo Advantage Small Cap Value Z
AIG-VALIC	Vanguard 500 Index	S&P 500 Flagship Fund D
AIG-VALIC	Franklin Temp Conservative Target A	Wells Fargo Outlook Today A
AIG-VALIC	Franklin Temp Moderate Target A	Wells Fargo 2010 A
AIG-VALIC	AIG VALIC Unallocated Fixed Account	Wells Fargo Stable Value

How Diabetic Supplies Are Covered under the FairChoice+BlueChoice POS and BluePreferred PPO Plans

FairChoice+BlueChoice POS Plan and BluePreferred PPO Plan both cover diabetic supplies such as lancets, oral medications, insulin, test strips, and syringes. Here's a summary of how these items are covered and how to determine your copayment or coinsurance for each item.

Different brands or types of medications, insulin, syringes and test strips fall under different prescription drug tiers. Your copay amount for these items will depend on which oral medication, insulin and test strips you use, the drug tier of the medication and whether you get a 30-day supply through your pharmacy or a 90-day supply through mail order. The copay amounts at the pharmacy for a 30-day supply are $10 for Tier 1 (generic)/$20 for Tier 2 (formulary brand)/$35 for Tier 3 (non- formulary brand).
The copay amounts through mail order for a 90-day supply are $20 for Tier 1 (generic)/$40 for Tier 2 (formulary brand)/$70 for Tier 3 (non-formulary brand).

Following is a list of some of the commonly-used Tier 1 and Tier 2 anti-diabetic drugs and blood sugar test strips as of September 1, 2005. This list appears on the CareFirst website at www.carefirst.com (click on Prescription Drug Information, then Preferred Drug List under "How to Use Your Drug Plan"). Be sure to check this list often as medications can change Tiers from time to time. If the medication and/or test strips that you use are not on the list, you should call Argus Health Systems, CareFirst's prescription drug provider, at 1-800-241-3371 to see what Tier and copay apply. If you are taking medication on Tier 2 or Tier 3, talk with your physician to see if an alternative is appropriate.

Tier 1	**Tier 2**
glipizide extended release (M)	ACTOS (M)
glipizide	AMARYL
glyburide and metformin (M)	AVANDAMET (M)
glyburide	AVANDIA
metformin xr (M)	LANTUS
metformin	NOVO INSULIN
rosiglitazone/metformin (M)	NOVOLOG
glucose test strips (M)	PRANDIN
	PRECOSE
	STARLIX
	Accu-Chek meter
test strips (M)	
	OneTouch meter
test strips (M)	

Lancets are considered a medical supply under the FairChoice+BlueChoice POS and BluePreferred PPO plans. If you obtain lancets from a network medical supply provider, the plan will pay 100% of the cost if a BlueChoice participating doctor orders the lancets and they are considered to be medically necessary. If you obtain lancets from an out-of-network provider, you will be responsible for paying the $250 out-of-network deductible (or any portion of the deductible you have not paid for the calendar year) and 30% of the allowed benefit amount, plus any amount in excess of the allowed benefit amount.

If you have any questions about the coverage of diabetic supplies or how much you've paid for these supplies, you can contact Betsi Fuhrman, CareFirst's onsite representative at 324-3474.

Dependent Definition Changed

(Continued from page 2)

- Unmarried;
- Under the age of 19; or age 19 but less than 23, and a full-time student (as defined by the accredited college, university, vocational or technical school).
- Disabled dependents, regardless of age, are eligible to remain on the County's health plan if the disability occurred before age 23.

Dependents added to the plan as of January 1, 2006 must meet these criteria. During 2006, the County will audit dependents to insure that the new criteria will be met. If the dependent does not meet the criteria, or if the employee does not respond to certification requests, the dependent will be dropped from the plan effective December 31, 2006.

Information retirees should know about benefits

If you are covered under a County life, health and/or dental plan at the time of your retirement, you may continue the insurance under the retiree group. You have 60 days after your coverage ends as an active employee to elect to continue your coverage as a retiree. The County reserves the right to change or terminate the benefit provided or adjust the premium at any time. If you are not covered by a County life, health or dental plan at retirement, you are not eligible for retiree coverage.

If you have retired from Fairfax County, you should contact the Retirement Administration Agency at 703-279-8200 or 800-333-1633 for information about continuation of health, dental, and/or life insurance coverage.

Who pays for retiree health and dental insurance?

Retirees pay the full cost of their health and/or dental insurance premiums. Health insurance premium rates are listed on page 4. Retirees age 55 or older, or those retired on a service-connected disability, receive a monthly subsidy from the County toward the cost of a County health plan. For 2006 only, the County has added an additional supplement. The 2006 subsidy is reflected in the table on page 3.

Retirees can pay their share of their health and/or dental insurance premiums in one of two ways. If possible, the cost will be deducted from the monthly annuity in the month prior to the month of coverage. If the individual does not receive an annuity or if the retiree's check is not large enough to cover the monthly premiums, the retiree must pay their monthly premiums by mailing a personal check payable to the County of Fairfax, to the Retirement Agency. Personal checks must be received by the Retirement Agency by the 10th of the month to cover the next month's coverage. Failure to make health and dental insurance payments on time may result in cancellation of the retiree's insurance coverage. Please remit personal checks, enrollment forms and change forms concerning retiree health/dental coverage to:

Retirement Administration Agency
10680 Main Street, Suite 280
Fairfax, VA 22030
(703) 279-8200 (800) 333-1633 fax: (703) 273-3185

Continuous coverage requirement

The County requires retirees to have continuous coverage in a Fairfax County Government (FCG) health and/or dental plan. The County, however, allows the coverage to be transferred from the active County government employee group to the retiree group and vice versa. Transfers to and from the Fairfax County Public Schools (FCPS) is not allowed for purposes of retaining continuous coverage, as FCPS is a separate employer. Two examples follow:

Got questions?

Call the specific health plan at the number listed below about plan coverage and identify yourself as a Fairfax County Government retiree. Call the retirement numbers listed below if you have more general questions about premiums, effective dates, and changes. Hearing impaired may call 703-222-7314.

<table>
<tr>
<td rowspan="2">Retirement – Asima Barzanji
703-279-8202 or 800-333-1633
County HR Staff
– Health/Dental -- Doug Sachs ,
703-324-3316
– Life Insurance -- Donna Dowd,
703-324-3374
CareFirst Help Desk --
Betsi Fuhrman. 703-324-3474</td>
<td>FairChoice+BlueChoice / BluePreferred PPO
800-296-0724
www.carefirst.com / www.bcbs.com</td>
<td>CIGNA
800-244-6224
www.cigna.com</td>
</tr>
<tr>
<td>Delta Dental
800-237-6060
www.deltadental.com</td>
<td>Kaiser and Kaiser Medicare Plus
301-468-6000
www.kaiserpermanente.org</td>
</tr>
</table>

Example 1: You are retiring and your spouse is also employed by FCG in a merit position. Your spouse may pick up coverage for both of you and any covered dependents when you retire. If your spouse is already enrolled in a FCG health plan, he or she may add you to the policy by filing an enrollment/change form with the Department of Human Resources within 60 days of your retirement date.

If your spouse terminates employment with FCG, you may pick up the coverage for both of you and any covered dependents through the Retirement Administration Agency by requesting the coverage within 60 days of your spouse's termination date. Coverage begins the first of the month after receipt of the enrollment form.

Example 2: You retire from FCG, then return to work for FCG in a merit position. The County will transfer your coverage back to the active employee group if you submit a new enrollment form to the Department of Human Resources within 60 days of your re-employment date. The effective date will be the first of the calendar month following receipt of the enrollment form by the Employee Benefits Division. At termination, your coverage will be transferred back to the Retirement Administration Agency if you complete another form requesting coverage through the retiree group.

Retirees whose retirement annuity has been suspended by the Retirement Administration Agency may pay for the full cost of their benefits by personal check as long as they are eligible to have their retirement benefits restored. If coverage is canceled by the retiree, or if a retiree's coverage is dropped because premiums have not been paid or because the retiree becomes ineligible, the retiree MAY NOT reenroll.

When can retirees make changes to their coverage?

New retirees have the following options within 60 days of retirement:

- You may continue in the same health plan that you had as an active employee until the next open enrollment period as long as you continue to meet the plan's eligibility and residency requirements. **Note:** CIGNA does not provide any coverage for retirees age 65 and older who are eligible for Medicare. Retirees or their dependents who turn age 65 on or after January 1, 2005 are not eligible to continue in Kaiser Permanente.

- If you are no longer eligible for coverage in your current plan (either due to Medicare or because you live outside of the plan's service area), you must elect other coverage for which you are eligible.

- Reduce coverage level (drop dependents).

- Drop coverage altogether. However, once dropped, coverage may never be reinstated.

Current retirees have the following options:

- If you move out of your HMO's service area, you must change to another plan serving the area in which you live. The change must be made within 60 days of the move. (Note: retirees disenrolling from Kaiser Medicare Plus are required to complete the Kaiser Medicare Plus Disenrollment Form.)

- Retirees or dependents turning 65 become ineligible for coverage in Kaiser and CIGNA. You must change to another plan serving the area in which you live. The change must be made within 60 days of becoming eligible for Medicare. NOTE: coverage will be cancelled with CIGNA or Kaiser on the date that an individual becomes eligible for Medicare. Enrollment in the new plan will be made retroactive to that cancellation date once the enrollment form is processed.

Retirees may **decrease coverage** (drop coverage or drop family members from their insurance) **at any time**. However, dependents may be added and levels of coverage may only be increased outside of an open enrollment period **due to a qualifying change in status**. Changes will take effect on the first of the month after receipt of the form, unless another date is required due to the specific qualified event. (see charts on pages 14-16).

Retirees eligible for Medicare

Retirees who become eligible for Medicare **must apply for Medicare Part A and Part B as soon as they are eligible**. Retirees are not required to elect Medicare Part D (see article on front page). After they receive Medicare coverage, Medicare becomes the primary source for payment of claims, and the FCG health plan becomes secondary.

Retirees or dependents must submit a copy of their Medicare card to the Retirement Agency showing effective dates of Part A and Part B coverage. The monthly premium for Medicare Part B will be deducted from their Social Security Check. Retirees must submit a copy of their Medicare card to the Retirement Agency as soon as it is available – up to three months prior to the effective dates. Submitting a copy of the card in this timely manner will limit the need for any retroactive adjustments in their check.

For most FCG health insurance plans, retirees with Medicare are responsible for paying the same deductible, co-payment, coinsurance and other out-of-pocket expenses that they would have been responsible for paying prior to receiving Medicare. However, under the FairChoice+BlueChoice plan, referrals for specialists are no longer required.

Retirees and dependents who have Medicare Part A and Part B coverage may be eligible for reduced health insurance premiums. Retirees who do not apply for and maintain Medicare Part A and Part B coverage will be responsible for the portion of their claims that Medicare would have paid.

Coverage for surviving spouses

Surviving spouses of deceased retirees may continue health and/or dental insurance coverage until they remarry. Surviving children may continue their coverage until they become ineligible because of age or loss of dependent status. If the survivors are not covered under a County plan at the time of the retirees' death, they are not eligible for coverage.

If a retiree or dependent with coverage dies, please contact the Retirement Administration Agency as soon as possible so that premiums can be adjusted.

Surviving spouses who are age 55 or older and who receive a survivor's benefit from the County are also eligible to receive a monthly subsidy (see chart on page 3). Surviving spouses who do not receive a survivor's benefit are not eligible for any subsidy.

If an active employee dies prior to retirement, his/her spouse may continue health and/or dental insurance through the Retirement Administration Agency if he/she is eligible to immediately receive a retirement annuity. This coverage may continue until he or she remarries. Surviving children may continue their coverage until they are no longer eligible. Surviving spouses of retirement-eligible active employees who are age 55 or older are also eligible to receive a monthly subsidy from the County if they elect to receive an annuity.

If an employee dies prior to becoming eligible for retirement, his/her survivors are eligible only for continuation coverage under COBRA. Survivors of retirees who become ineligible for coverage may also be eligible for COBRA coverage. Call Human Resources at 703-324-3316 for more information.

Kaiser Permanente Medicare Plus Plan

Kaiser Permanente's Medicare Plus plan is available for members who were enrolled in this plan as of December 31, 2004. New retirees or their dependents who are age 65 and current retirees or their dependents who turn 65 must choose other coverage. To remain eligible for this coverage, current members must live within the plan's service area (and not reside out of the service area for more than 90 days per year). If the retiree or dependent loses eligibility for this plan, the County will allow the retiree to change to another health plan within 60 days of the loss of eligibility so that he/she is covered in a County health plan continuously.

Retirees under the Kaiser Medicare Plus plan must use Kaiser Permanente providers in order to receive non-emergency benefits from Kaiser. However, they may use their Medicare card at other providers to receive Medicare benefits for any covered service. To disenroll from this plan (even to change to another plan), retirees must complete a special disenrollment form that is available from the Retirement Administration Agency at 703-279-8200 or 800-333-1633. The completed form must be returned to the Retirement Administration Agency.

Retirees must reside in their plan's service area

All health plans (except Blue Preferred PPO) require retirees to live in one of the zip codes that make up their service area. If your zip code (based on your address on file with the Retirement Administration Agency) is not

included in the service area, you must elect other coverage. This is true even if you change your address for a short time or if your home is in the service area but the post office with your zip code is out of the service area. A general description of the service area for each plan is listed below.

For information about specific zip codes covered by each plan, consult the plan materials or call the customer service number for your plan. If you move outside of the service area of your plan, you MUST notify the Retirement Administration Agency and change to a new plan within 60 days of your move. Failure to do so could result in your claims not being paid or the loss of eligibility for coverage under the retiree group.

If you move into the service area of a plan, you must wait until the annual open enrollment period to enroll in that plan.

HEALTH PLAN SERVICE AREAS

FairChoice+BlueChoice

Arlington, Alexandria, Fairfax County and City, Falls Church, Prince William County, City of Manassas, City of Manassas Park, Loudoun County, Leesburg, the entire state of Maryland and DC.

Kaiser and Kaiser Medicare Plus

DC, Maryland: Baltimore, Montgomery, Carroll, Harford, Anne Arundel, Prince George's and Howard Counties and some of Calvert, Charles, Frederick County; Virginia: Arlington, Alexandria, Fairfax, Prince William, Loudoun, Falls Church, Manassas and Manassas Park.

CIGNA

Maryland: Most of Garrett, Allegany, Washington, Frederick, Carroll, Baltimore, Harford, Howard, Anne Arundel, Montgomery, Prince Georges, Charles, St. Mary's, Cecil, Calvert, *Virginia:* Abemarle, Alexandria, Amelia, Amherst, Arlington, Augusta, Bedford, Botetourt, Buckingham, Campbell, Caroline, Charles City, Chesapeake, Chesterfield, Clarke, Culpeper, Cumberland, Dinwiddie, Fairfax, Falls Church, Fauquier, Floyd, Fluvania, Franklin, Frederick, Giles, Gloucester, Goochland, Greene, Hampton, Hanover, Henrico, Henry, Hopewell, Isle of Wright, James City, King and Queen, King George, King William, Loudoun, Louisa, Lynchburg, Madison, Mathews, Middlesex, Montgomery, Nelson, New Kent, Newport News, Norfolk, Nottoway, Orange, Page, Patrick, Petersburg, Pittsylvania, Poquson, Portsmouth, Powhatan, Prince William, Prince George, Pulaski, Rappahannock, Richmond, Roanoke, Rockingham, Shenandoah, Spottsylvania, Stafford, Suffolk, Surry, Sussex, Virginia Beach, Warren and York and all of Washington, *DC*.

Who pays for retiree life insurance?

The County pays for 1/2, 1/3, 1/4 or 1/5 or all of the premium for life insurance coverage, depending upon the coverage selected.

- Retirees who elect to continue either basic coverage (one times salary) or basic plus one times salary optional coverage will pay for 1/2 of the premium at age banded rates.
- Retirees who continue basic plus two times salary optional coverage will pay for 2/3 the premium.
- Retirees who continue basic plus three times salary optional coverage will pay for 3/4 of the premium.
- Retirees who elect basic plus four times salary optional coverage will pay for 4/5 of the premium.
- Retirees who opt to reduce their coverage to $12,500 will pay for 50 percent of the coverage at age banded rates and will have no further contractual coverage reductions.
- At age 80, retirees are eligible to reduce their coverage to $12,500 and the County will pay the entire premium.

The rates for retirees are two cents less than the age banded rates for active employees because of the discontinuation of Accidental Death and Dismemberment coverage. The monthly premium rates for dependent coverage are the same premium rates that active employees pay. The coverage level for dependent coverage follows: High option is $12,500 for your spouse and $6,250 for your eligible dependent children;

(continued on page 16)

Age	Monthly Premium Rate per $1,000 of coverage
Under 30	$0.07
30-49	$0.15
50-59	$0.29
60-79	$0.47
80-84	$4.02
85-89	$6.81
90-94	$20.02

HEALTH CARE BENEFITS AT-A-GLANCE

FAIRCHOICE+BLUECHOICE

	In-Network	Out-of-Network
Annual Deductible	None	$250 per person (with family coverage, only two family members must meet the deductible).
Yearly Out-of-Pocket Limit	None	$2,500 per person (does not include deductible). Once two family members meet the out-of-pocket limit, the entire family has met the out of pocket limit for the remainder of the year.
Lifetime Maximum Benefits	None	$1,000,000 per person in covered major medical benefits.**
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.* Physical exams limited to one per calendar year.
Inpatient Hospital Care	Covered in full.	Covered at 70% of plan allowance after deductible.*
In Hospital Doctors' Services	Covered in full.	Covered at 70% of plan allowance after deductible.*
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**	Covered at 70% of plan allowance after deductible* for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**
Maternity Care	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.*
Well Baby Care	Covered in full after $10 co-pay.	Unlimited well child visits to age 18, including immunizations, are covered at 70% of plan allowance not subject to deductible.*
Mental Health Services	**Inpatient –** Covered in full for up to 30 days per calendar year;* 90 day lifetime maximum. (Physician covered in full after $25 co-pay for one visit per day up to 30 days per calendar year.) **Outpatient –** Covered in full after $25 per visit co-pay, up to 20 visits per calendar year. *Limit is shared between mental health and substance abuse.	**Inpatient –** covered at 70% of plan allowance after deductible,* up to 20 days per calendar year for covered participants age 23 or older (25 days per calendar year for covered participants under 23). **Outpatient –** visits 1-5 per calendar year: covered at 70% of plan allowance after deductible,* thereafter 50% of plan allowance after deductible for unlimited number of visits.
Alcohol and Drug Abuse Treatment	Same as mental health.	Same as mental health.
Prescription Drugs	*Retail* (up to 34 day supply): $10 – co-pay for generic drugs $20 – co-pay for formulary brand name drugs $35 – co-pay for non-formulary brand name drugs. *Mail order* (up to 90 day supply): $20 – co-pay for generic drugs $40 – co-pay for formulary brand name drugs $70 – co-pay for non-formulary brand name drugs.	Same as In-Network.
Laboratory & X-ray	Covered in full at approved radiology and laboratory centers, $25 co-pay at approved outpatient department of hospital.	Covered at 70% of plan allowance after deductible.*
Routine Vision Care	Eye exams covered in full after $10 co-pay at participating Davis vision providers. Discount on eyewear. Call Davis vision at 800-783-5602 for network vision providers	Eye exams covered in full after $10 co-pay at participating Davis vision providers. Discount on eyewear. Call Davis vision at 800-783-5602 for network vision providers
Dental Care	Discounts on services provided by participating dentists.	Routine care not covered.
Physical Therapy	Covered in full after $10 co-pay, up to 90 days per condition per calendar year.	Covered at 70% of plan allowance after deductible.*
Emergency Treatment	Covered in full after $50 co-pay for a bona fide accidental injury or medical emergency. (Waived if admitted.) Otherwise benefit will be provided out-of-network.	Benefits provided in-network for a bona fide accidental injury or medical emergency. Otherwise, covered at 70% of plan allowance after deductible.*

* After maximum out-of-pocket amount is reached, plan pays at 100% of plan allowance. **FairChoice+BlueChoice and BluePreferred PPO combined.

HEALTH CARE BENEFITS AT-A-GLANCE

BLUEPREFERRED PPO

	In-Network	Out-of-Network
Annual Deductible	None	$250 per person (with family coverage, only two family members must meet the deductible).
Yearly Out-of-Pocket Limit	$1,000 per person (does not include deductible or co-payments). Two family members must meet out-of-pocket limit.	$2,500 per person (does not include deductible). Once two family members meet the out-of-pocket limit, the entire family has met the out of pocket limit for the remainder of the year.
Lifetime Maximum Benefits	None	$1,000,000 per person in covered major medical benefits.**
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay.	Covered at 70% of plan allowance after deductible.* Physical exams limited to one per calendar year.
Inpatient Hospital Care	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Inpatient Physician Billed Services	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime covered at 90% of plan allowance.* $100,000 lifetime maximum.**	Covered at 70% of plan allowance after deductible* for in-vitro fertilization for up to 3 completed attempts per lifetime. $100,000 lifetime maximum.**
Maternity Care	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Well Baby Care	Covered in full after $10 co-pay.	Unlimited well child visits to age 18, including immunizations, are covered at 70% of plan allowance not subject to deductible.*
Mental Health Services	**Inpatient –** Covered at 90% of plan allowance* up to 30 days per calendar year;** 90 day lifetime maximum**. Physician billed services –** 90% of plan allowance.* **Outpatient –** Covered at 90% of plan allowance,* up to 20 visits per calendar year. **Limit is shared between mental health and substance abuse.	**Inpatient –** covered at 70% of plan allowance after deductible,* up to 20 days per calendar year for covered participants age 23 or older (25 days per calendar year for covered participants under 23). **Outpatient –** visits 1-5 per calendar year: covered at 70% of plan allowance after deductible,* thereafter 50% of plan allowance after deductible* for unlimited number of visits.
Alcohol and Drug Abuse Treatment	Same as mental health.	Same as mental health.
Prescription Drugs	*Retail* (up to 34 day supply): $10 – co-pay for generic drugs $20 – co-pay for formulary brand name drugs $35 – co-pay for non-formulary brand name drugs. *Mail order* (up to 90 day supply): $20 – co-pay for generic drugs $40 – co-pay for formulary brand name drugs $70 – co-pay for non-formulary brand name drugs.	Same as In-Network.
Laboratory & X-ray	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Routine Vision Care	Eye exams covered in full after $10 co-pay at participating Davis vision providers. Discount on eyewear. Call Davis vision at 800-783-5602 for network vision providers	Eye exams covered in full after $10 co-pay at participating Davis vision providers. Discount on eyewear. Call Davis vision at 800-783-5602 for network vision providers
Dental Care	N/A	N/A
Physical Therapy	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*
Emergency Treatment	Covered at 90% of plan allowance.*	Covered at 70% of plan allowance after deductible.*

* After maximum out-of-pocket amount is reached, plan pays at 100% of plan allowance. **FairChoice+BlueChoice and BluePreferred PPO combined

HEALTH CARE BENEFITS AT-A-GLANCE

	KAISER	CIGNA
Annual Deductible	None	None
Yearly Out-of-Pocket Limit	N/A	$1,000 individual. $2,000 family.
Lifetime Maximum Benefits	None	None
Office Visits, Physical Exams and Routine Immunizations	Covered in full after $10 co-pay; $0 co-pay for children up to 5 years of age.	Covered in full after $10 co-pay per visit.
Inpatient Hospital Care	Covered in full.	Covered in full.
In Hospital Doctors' Services	Covered in full.	Covered in full.
Infertility Coverage	Coverage for infertility services for in-vitro fertilization for up to 3 completed attempts per lifetime; covered at 50% of allowable charges.	Cover office visits, diagnosis and medical/surgical treatment **excluding** drugs, in-vitro, GIFT, ZIFT, etc. $10 co-pay; plus 50% coinsurance applies to physician's charges for treatment/surgical procedures.
Maternity Care	Covered in full after a $10 co-pay on the first prenatal visit.	Covered in full after a $10 co-pay on the first pre-natal visit.
Well Baby Care	Covered in full; $0 co-pay up to 5 years of age; $10 co-pay per visit thereafter.	Covered in full after $10 co-pay per visit.
Mental Health Services	**Inpatient –** Covered in full when medically necessary. **Outpatient -** $10 co-pay per visit when medically necessary.	**Inpatient –** Covered in full when medically necessary. **Outpatient –** Visits 1-5: $10 co-pay per visit. Visits 6-30: $20 co-pay per visit. Visits 31+; $25 co-pay per visit. **Group –** Visits 1-5: $10 co-pay per visit.Visits 6+: $20 co-pay per visit.
Alcohol and Drug Abuse Treatment	Same as mental health.	Same as mental health.
Prescription Drugs	Kaiser pharmacy (up to 30 day supply): $10 co-pay for generic drugs $20 co-pay for brand formulary $35 co-pay for non-formulary Community pharmacy (up to 30 day supply): $20 co-pay generic $40 co-pay brand formulary $55 co-pay non-formulary Mail order (up to 90 day supply): $16 co-pay generic $36 co-pay brand formulary $66 co-pay non-formulary	Retail (up to 30 day supply) $10 co-pay for generic drugs, $20 co-pay for preferred brand drugs and $40 co-pay for non-preferred brand drugs. Mail order (up to 90 day supply): $20 co-pay generic; $40 co-pay preferred brand name; $80 co-pay non-preferred brand
Laboratory & X-ray	Covered in full.	Covered in full.
Vision Care	Covered in full after $10 co-pay for optometry (eye refraction exam only) and ophthalmology visits; 25% eyeware discount; 15% initial fitting and contact lens discount.	$10 co-pay for eye exams every 24 months at a participating provider. Dollar allowances provided toward purchase of materials and hardware.
Dental Care	Discounts on services.	N/A
Physical Therapy	Short-term therapy covered in full after $10 co-pay per visit. 90 day limit per incident per contract year.	Covered in full after $20 co-pay per visit. Maximum benefit of 60 visits per contract year.
Emergency Treatment	Covered in full after $50 co-pay per visit. Waived if admitted.	Covered in full after $50 co-pay per visit for emergency room; $25 co-pay per visit for urgent care facility. Waived if admitted

QUALIFYING CHANGE IN STATUS EVENTS

The following events, as specified in Section 125 of the Internal Revenue Code, the Health Insurance Portability and Accountability Act (HIPAA) and other federal regulations, govern the occasions when you can enroll, cancel or change your coverage OUTSIDE of the open enrollment period. The change requested must be on account of, and consistent with, the qualifying event. If the requested change does not meet both the qualifying event and consistency rules, the request for change cannot be approved. **NOTE**: A voluntary cancellation is not a qualifying event.

In order to make changes to your health or dental coverage, you must file the appropriate form within 60 days of the qualifying event. Change forms must be received by the Retirement Administration Agency within 60 calendar days of the qualifying event or loss of coverage, whichever is later. If the change is due to birth, adoption, placement for adoption or due to dependent's loss of eligibility for other coverage, any benefit plan may be elected. **All changes take effect the first of the month following receipt of the form, except for birth, adoption or placement for adoption, which become effective on the date of birth or adoption. IMPORTANT: Some qualifying change of status events listed below may not apply to retirees.**

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.
Marriage	To add a spouse and any eligible dependents, file a change form within 60 days of the marriage. To drop County health plan coverage because you will be covered by your new spouse, file a change form within 60 days of the marriage. Uninsured employees may enroll, add a spouse and all newly eligible dependents (i.e. stepchildren).	Fairfax County Enrollment/Change form; and A copy of your marriage certificate and birth certificates for any children for whom you are requesting coverage (or proof of birth letter for newborns). You must also notify Social Security and Payroll of any name change.
Birth of a child	To add a newborn child, a change form must be filed with the Employee Benefits Division within 60 days of birth. Spouse and other newly eligible dependents may also be added. Uninsured employees may enroll, add a spouse and all newly eligible dependents (i.e. stepchildren).	Fairfax County Enrollment/Change form; and A copy of child's birth certificate (or proof of birth letter). Marriage certificate, and birth certificates for other children, if applicable.
Adoption or placement for adoption	Change form must be filed with the Employee Benefits Division within 60 days of adoption or placement for adoption. Spouse and other newly eligible dependents may also be added. Uninsured employees may enroll, add a spouse and all newly eligible dependents (i.e. stepchildren).	Fairfax County Enrollment/Change form; and Legal documentation showing date of adoption or legal placement. Marriage certificate, and birth certificates for other children, if applicable.
Divorce	To drop your former spouse and children who are not your dependents, file a change form within 60 days of the divorce. If you have lost coverage through your spouse as a result of divorce, file change form within 60 days of loss of coverage to elect coverage with the County.	Fairfax County Enrollment/Change form; and Copy of the first and last page of the divorce decree; and HIPAA certificate or letter from spouse's health plan or employer showing the date the coverage ended (for employees who are electing coverage due to loss of coverage under the former spouse's plan).
Obtaining legal guardianship of a child	A change form must be filed with the Employee Benefits Division within 60 days of the date legal guardianship is granted.	Fairfax County Enrollment/Change form; and Court documents showing that the employee has been appointed legal guardian for the child. (Not simply a change in custody.)
Death of employee, spouse or dependent	File a change form within 60 days of date of death. If the employee who was previously covered under spouse's plan, he/she may elect coverage under Fairfax County's plan within 60 days. Spouse or dependents who were covered under Fairfax County's plan must be removed within 60 days. Effective date is the end of the month in which the employee died.	Fairfax County Enrollment/Change form; and HIPAA certificate or letter from spouse's health plan or employer showing the date the coverage ended (for employees who are electing coverage due to loss of coverage under the spouse's plan).

QUALIFYING CHANGE IN STATUS EVENTS (continued)

EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.
Dependent child reaches plan age limit or ceases to meet eligibility requirements under the plan.	To drop a dependent, file a change form within 60 days of the status change.	Fairfax County Enrollment/Change form.
Employee or dependent reaches lifetime limit for ALL benefits.	File change form within 60 days of reaching lifetime limit or within 60 days of first claim denied for that reason.	Fairfax County Enrollment/Change form; and Health plan documentation with proof that lifetime limit has been reached.
Change in employment status of the employee or spouse that affects health or dental coverage, including: - termination or commencement of employment; - strike or lockout; - commencement of or return from an unpaid leave of absence; - change in worksite or any other change in employment status that results in an employee, spouse or dependent becoming eligible for or losing eligibility for coverage; - cessation of employer contributions toward premium; - spouse's employer no longer offers coverage to the class of employees that include the spouse.	To elect coverage with the County, file a change form within 60 days of loss of coverage. To add spouse/dependents who had been covered under spouse's plan, file a change form within 60 days of loss of coverage.	Fairfax County Enrollment/Change form; and A copy of your marriage certificate or last tax return indicating filing married (if adding spouse) and birth certificates for children (or proof of birth letter for newborns); and HIPAA certificate or letter from other plan documenting date coverage was lost, family members who were covered and type of coverage with which you were enrolled.
	To drop County coverage, file a change form within 60 days of the effective date of coverage under the other plan.	Fairfax County Enrollment/Change form
Employee or dependent loses eligibility for Medicare or Medicaid or State Children's Health Insurance Program or COBRA coverage (must be involuntary).	File enrollment or change form within 60 days of coverage loss to add or increase coverage under the plan.	Fairfax County Enrollment/Change form; and Copy of official notification letter indicating loss of eligibility and reason for loss of coverage; and If adding spouse or eligible dependent children, copy of marriage certificate/tax form and birth certificates for children.
Court orders (including judgments, decrees or qualified medical child support orders)	File change form to add or drop coverage within 60 days of event (change must be consistent with the court order and the order must be directed to the County and not to any to any other party).	Fairfax County Enrollment/Change form; and Copy of court order; and If dropping your child(ren) because someone else has been ordered to provide coverage, proof that child(ren) have been enrolled in other coverage. Effective date is determined by court order.

QUALIFYING CHANGE IN STATUS EVENTS (continued)		
EVENT	EMPLOYEE ACTION NEEDED	DOCUMENTATION REQ'D.
Employee moves and no longer resides within the HMO's service area or spouse's HMO coverage is lost because he or she no longer lives or works in the service area of that HMO and no alternative coverage is available from his or her employer.	To change health plans or drop coverage, file a change form within 60 days of the change of residence.	Fairfax County Enrollment/Change form; and Documentation showing change in address; and. If electing or changing coverage because of cancellation of spouse's coverage due to no longer living or working in the HMO's service area, copy of HIPAA certificate or other document from spouse's employer.
Commencement of unpaid FMLA Leave:	No action is required; employee will continue with same health/dental coverage election in effect provided that premiums are paid. Employee share of premium is due while on FMLA leave. May elect to drop coverage while on unpaid FMLA leave.	Fairfax County Enrollment/Change form if dropping coverage
Return from unpaid FMLA Leave:	If coverage was dropped, may elect to be reinstated to coverage in effect prior to FMLA leave.	Fairfax County Enrollment/Change form
Open enrollment of a spouse	If your spouse has a different plan year than the County's calendar year coverage period, you can change your health coverage election on account of an action that your spouse has taken that affects your coverage under his/her plan. NOTE: If spouse's plan year is the same as the County's plan year, you must make your change during the County's open enrollment period. To pick up coverage with the County, file a change form within 60 days of loss of coverage. To drop coverage with the County, file a change form with 60 days of the effective date of the new coverage.	Fairfax County Enrollment/Change form; and A copy of your marriage certificate or last tax return indicating filing married and birth certificates for children (or proof of birth letter for newborns). To request that County coverage be dropped, file a change form within 60 days of the effective date of the new spouse coverage.

*You may enroll in dental coverage (or drop dental coverage) if a consistent change is also being made to other comparable coverage (i.e. you add your spouse to your dental coverage because your spouse lost dental coverage due to a change in employment status.)

Information retirees should know *(Continued from page 10)*

Low option is $6,250 for your spouse and $2,500 for your eligible dependent children. The County does not make a contribution for dependent coverage.

Long-Term Care Insurance

Long-term care refers to services you may need if you become unable to care for yourself. Long-term care insurance provides a daily benefit when you are unable to perform at least two of the six activities of daily living, defined as: bathing, dressing, eating, transferring, toileting and continence, or when you have a severe cognitive impairment such as Alzheimer's disease. You must elect this coverage in order to be enrolled. You choose where you want your care: at home, an assisted living facility, nursing home, adult day care or hospice. Benefits begin after a 90-day waiting period.

Retirees, spouses of retirees, surviving spouses of retirees and adult children of retirees may apply for the coverage at any time. Applicants must complete an enrollment form and a medical questionnaire, and be approved by Aetna. Forms may be downloaded at http://www.aetna.com/group/fairfaxcounty or you may call the Aetna hotline at 800-537-8521 or Human Resources at 703-324-3437 for more information.